State of Wyoming

Department of Health

Rules and Regulations for Medicaid Supports and Comprehensive Waivers

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Chapter 46
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CHAPTER 46

RULES AND REGULATIONS FOR MEDICAID
SUPPORTS AND COMPREHENSIVE WAIVERS

Section 1. Authority.

This Chapter is promulgated by the Department of Health pursuant to W.S. 9-2-102, the Medical Assistance and Services Act at W.S. §§ 42-4-104 and 42-4-120, 2013 Wyoming Session Laws 322-325, and the Wyoming Administrative Procedure Act at W. S. § 16-3-101 through 16-3-115.

Section 2. Purpose and Applicability.

(a) This Chapter shall apply to and govern Medicaid services provided under the Wyoming Medicaid Supports and Comprehensive Waivers.

(b) The Behavioral Health Division, hereafter referred to as the "Division", may issue manuals, bulletins, or both, to providers or other affected parties to interpret the provisions of this Chapter. Such manuals and bulletins shall be consistent with and reflect the policies contained in this Chapter. The provisions contained in manuals or bulletins shall be subordinate to the provisions of this Chapter.

Section 3. General Provisions.

(a) Terminology. Unless otherwise specified, the terminology used in this Chapter is standard terminology and has the standard meaning used in accounting, health care, Medicaid, and Medicare.

(b) The requirements of Title XIX of the Social Security Act, 42 C.F.R. § 441.1 Subpart G, and the Medicaid State Plan apply to Medicaid and are incorporated by this reference as of the effective date of this Chapter, and may be cross-referenced throughout this Chapter where applicable. This incorporation by reference does not include any later amendments or editions of the incorporated matter. The incorporated rules and regulations may be viewed at http://www.ecfr.gov/cgi-bin/ECFR. The Medicaid state plan may be viewed at http://www.health.wyo.gov/healthcarefin/medicaid/spa.html. These materials may be obtained at cost from the Department.

(c) This Chapter establishes a person-centered approach to determining the support needs of participants in the Individualized Plan of Care and to assign the individual budget amount. Developing community connections, increasing independence, natural supports, self-direction, and employment opportunities are essential components of the Supports and Comprehensive Waivers.

(d) The Supports Waiver provides eligible participants supportive services so the person may remain in the place he or she currently lives, as funding is available.

(e) Objectives. In conjunction with the methodology listed in this Section, objectives of the Supports and Comprehensive Waivers include:

(i) Provide an array of services, including a continuum of support and employment offerings, to serve participants in the least restrictive and most appropriate environment;

(ii) Provide participants increased opportunities for community involvement;

(iii) Allow the opportunity to self-direct services;

(iv) Set and achieve targeted outcomes for each participant served; and

(v) Monitor and enhance continuous improvement strategies to improve service delivery for participants.

Section 4. Philosophy.

(a) All persons possess inalienable rights under the Constitutions of the United States and the State of Wyoming. Persons with developmental disabilities also possess the rights outlined in the Developmental Disabilities Assistance and Bill of Rights Act of 2000, 42 U.S.C. §15001.

(b) It is the philosophy of the Division to develop reasonable and enforceable rules for the provision of services to individuals with developmental disabilities, acquired brain injury, and related conditions in community settings in lieu of unnecessary institutionalization. This philosophy is mandated in the Supreme Court ruling on *Olmstead v. L.C. ex rel. Zimring,* 527 U.S. 581 (1999).

(c) This Chapter is designed not only to support the philosophy of home and community-based services, but also to protect the health, welfare, and safety of waiver participants.

Section 5. Assessment and Eligibility.

(a) Eligibility under this Chapter is limited to persons who complete the application process and who meet the following requirements for clinical eligibility and financial eligibility. In order to be eligible for the waiver all persons shall:

(i) Be a legal United States citizen according to Chapter 18 of Wyoming Medicaid Rules;

(ii) Be a Wyoming resident as determined by Chapter 18 of Wyoming Medicaid Rules;

(iii) Meet ICF/ID level of care services;

(iv) Meet financial eligibility as determined by Chapter 18 of Wyoming Medicaid Rules;

(v) Meet one of the following clinical eligibility diagnoses:

(A) A diagnosis of an intellectual disability with an Intelligence Quotient (IQ) score two standard deviations or more below the population mean, including a margin of measurement error within + 5 points, with a max score of 65–75 (70 ± 5) as determined by a clinical

psychologist independent from the provider of waiver services, who has a current and valid license, with verification in a psychological evaluation; or

(B) A developmental disability or a related condition determined by a physician or independent psychologist currently licensed in Wyoming with verification in medical records or a psychological evaluation with assessment scores included. The evaluation or records must identify a severe, chronic disability, which:

(I) Is attributable to a mental or physical impairment, other than mental illness, or combination of both.

(II) Is likely to continue indefinitely.

(III) Results in substantial functional limitations in three (3) or more major life activity areas: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency, as verified in the evaluation by the same physician or psychologist.

(IV) Has qualifying adaptive behavior scores as determined through standard measurement of adaptive behavior, using the most current forms of the Vineland or Adaptive Behavior Assessment System. For those with a diagnosis along the Autism Spectrum Disorder, a current autism evaluation must be completed.

(C) A child applicant who is old enough to take an Intelligence Quotient test shall meet a qualifying clinical diagnosis like an adult. A child too young to complete an Intelligence Quotient test may meet the criteria of a developmental disability as defined in subsection (B) through medical records of a related condition using a standardized test of development, such as the Bayley Scales of Infant and Toddler Development.

(D) In addition, one of the following conditions must be met:

(I) The diagnosis and condition reflects the need for a combination and sequence of special services which are lifelong or of extended duration; or

(II) The diagnosis and condition manifested before the person turned age twenty-two (22).

(vi) Qualifies on the Inventory for Client and Agency Planning (ICAP) assessment with one of the following:

(A) If age twenty-one (21) or older, a service score of 70 or less;

(B) If age twenty-one (21) or older with an ICAP service score above 70, the applicant must at least three (3) significant functional limitations listed in the following sections of the ICAP: Personal Living domain, Social/Communication domain, Community Living Domain, a diagnosis of an intellectual disability, or is non-ambulatory without assistance.

(C) If age two (2) through seventeen (17) with an ICAP service score between 30 and 70, respectively depending on age.

(D) If age twenty (20) or below, the age adjusted ICAP service score must be higher than the ICAP service score for his or her actual age and meet eligibility based on their Adaptive Behavior Quotient (ABQ):

(I) For ages zero (0) through five (5), an adaptive behavior quotient of .50 or below;

(II) For individuals age six (6) through twenty (20), an adaptive behavior quotient of .70 or below.

(b) Diagnoses and assessments used to meet initial clinical eligibility must be accurate and no more than five (5) years old. Any assessments or reassessment for eligibility are subject to review by the Division before acceptance and may require additional evidence or verification.

(c) For participation in the Comprehensive Waiver, an individual shall meet the clinical eligibility specified in this section and have assessed service needs in excess of the cost limit on the Supports Waiver, or meet the emergency criteria as approved by the Extraordinary Care Committee (ECC), or meet the criteria for reserved capacity. Transition to the Comprehensive Waiver shall only occur as funding and a slot on the Comprehensive Waiver becomes available.

(d) Loss of eligibility.

(i) A participant shall be determined to have lost eligibility when the participant:

(A) Does not meet clinical eligibility when re-assessed; or

(B) Does not meet financial eligibility; or

(C) Changes residence to another state.

(ii) Services to a participant determined not to meet eligibility requirements shall be terminated no more than forty-five (45) days after the determination is made. If an applicant is determined not to meet eligibility criteria, the applicant or the applicant's legal representative shall be notified in writing within fifteen (15) business days.

(iii) A participant may be denied waiver eligibility and may be required to reapply when the participant:

(A) Voluntarily does not receive any waiver services for three (3) consecutive months;

(B) Is in a nursing home, hospital, or residential treatment facility, institution, or ICF/ID for six (6) consecutive months; or

(C) Is in an out-of-state placement or residence for six (6) consecutive months or resides out of state for six (6) consecutive months.

(iv) Upon written notification of the denial of waiver eligibility:

(A) The participant or legally authorized representative may submit, in writing, a request for reconsideration, which shall include the reasons why he/she should still be considered eligible for the services.

(B) The Division Administrator or Designee shall review this request.

(v) If the participant is determined not to be eligible for services due to one of the criteria in (iii) of this Section, the participant or the participant's legally authorized representative shall be notified in writing within fifteen (15) business days.

(e) Reassessments.

(i) A participant shall be reassessed for level of care and clinical eligibility at least annually or more frequently at the option of the Division. Financial eligibility is reassessed annually.

(ii) The psychological evaluation shall be completed before initial waiver eligibility is determined, then as necessary by the participant's change in condition with prior approval by the Division.

(iii) The ICAP assessment shall be completed every five (5) years, or more frequently at the option of the Division, to provide continued verification that the participant meets waiver clinical eligibility.

(iv) The Division may require other assessments to determine budget amounts or service authorization.

(v) Psychological reassessments must be conducted by an entity without a conflict of interest to the providers chosen by the participant. The Division shall review all eligibility assessments.

Section 6. Statewide Data Registry.

(a) All individuals who have been determined eligible for waiver services shall be included in the statewide data registry used by the Division for planning, monitoring, and analysis for the waiver system. Information in the registry is considered confidential and will not be released without proper authorization, or otherwise as required by law. Providers shall provide data on programs, participant outcomes, costs, and other information as required by the Division.

Section 7. Waiver Services, Service Requirements, and Restrictions.

(a) All waiver services specified in the plan of care must be based on the participant's assessed needs; be considered medically or functionally necessary; align with the participant's preferences for services, supports, and providers; and be prioritized based on the availability of funding in the participant's budget.

(b) The individualized plan of care must be developed using person-centered practices and planning, including the preferences and outcomes desired by the participant, and address the assessed needs, potential risks and plans to mitigate risks. The plan must describe the type, scope,

frequency, amount and duration of services to be provided to the participant. The plan must also identify the provider, or provider types, that furnish the described services, regardless of the funding source.

(c) Waiver services must be intended to assist the participant in acquiring, retaining, and improving the skills necessary so the individual can function with as much independence as possible, exercise choice and self-management, and participate in the rights and responsibilities of community membership.

(d) The approved plan of care shall reflect the services, and actual units that providers agree to provide over the plan year. The approved plan of care shall also include details regarding the specific support to be provided in various settings, times of day, and for specific activities that require more support than others.

(e) Services available on the Supports and Comprehensive Waiver are approved by the Centers for Medicaid and Medicare Services in the waiver application.

(f) Providers cannot serve children under age 18 and adults at the same time unless prior authorized in writing by the Division.

(g) Waiver services shall not be used to duplicate a same service or a similar service that is available to the participant through one of the following programs:

(i) Section 110 of the Rehabilitation Act of 1973;

(ii) Section 504 of the Rehabilitation Act of 1973; or

(iii) Individuals with Disabilities Education Act (IDEA) (20 U.S.C. 1401 et seq.);

(iv) Medicaid State Plan; or

(v) Local communities or school districts.

(h) Participants may request an exemption from subsection (d) by submitting a third payer liability form as part of the participant's annual plan of care. This form must document that the service is not available through another program or agency to meet the individual participant's assessed needs. Exemptions may be granted at the direction of the Division.

(i) Routine transportation for activities provided during a service are included in the reimbursement rate for the service regardless of the number of trips, therefore the participant may not be charged separately for transportation during the waiver activity unless the special activity is outside of the participant's community or normal routine.

(j) For a person in a residential habilitation placement, day services that include Companion services, Adult Day Services, Community Integration, or Prevocational services Service have a combined limit of 35 hours per week.

(k) Waiver services include:

(i) Adult Day Services:

(A) Adult Day Services are structured services for participants ages twenty-one (21) and older and consist of meaningful day activities that maximize or maintain skills and abilities and keep participants engaged in their environment and community through optimal care and support. Services may improve or maintain flexibility, mobility, and strength, or build on previously learned skills.

(B) Services are non-habilitative and a participant may not be paid for work activities performed during this service.

(C) Services also include assistance with personal care, protective oversight, and health maintenance activities, such as medication and living routine assistance.

(D) Tiered service rates must be based upon level of service need:

(I) Basic Level of Care for participants between a level 1 and 2.9 Level of Service Need score, which requires limited staff supports and personal attention to a participant daily due to a moderately high level of independence and functioning. Behavioral needs, if any, can be met with medication or informal direction by staff. The participant may have periods of time with indirect staff supervision where staff are onsite and available through hearing distance of a request.

(II) Intermediate Level of Care for participants between a level 3 and 4.9 Level of Service Need score, which requires full-time supervision with staff available on-site within line of sight due to significant functional limitations, medical or behavioral needs. Behavioral and medical supports are not generally intense and can be provided in a shared staffing setting. Regular personal attention is given throughout the day for personal care, reinforcement, community or social activities.

(III) High Level of Care for participants between a level 5 and 6 Level of Service Need score, which requires full-time supervision with staff available on-site within absolute line of sight and frequent staff interaction and personal attention for significant functional limitations, medical or behavioral needs. Support and supervision needs are moderately intense, but can still generally be provided in a shared setting unless otherwise specified in the plan of care. Frequent personal attention given throughout the day for reinforcement, positive behavior support, personal care, community or social activities.

(E) Adult Day Services may be provided at a residential site, if the participant's plan of care team decides the home is a more appropriate place to receive the service and the approved plan of care supports the medical, behavioral, or other reason for the service to be provided in the person's home.

(ii) Behavioral Support Services:

(A) Behavioral Support Services include training, supervision, or assistance in appropriate expression of emotions and desires, compliance, assertiveness, acquisition of socially appropriate behaviors, and the reduction of inappropriate behaviors through the implementation of positive behavior support and interventions. Behavioral Support services may be accessed for the

purpose of reducing the use of restrictions and restraints within a participant's current plan of care or service environment.

(B) Behavioral Support services provided must not be covered under any billable service through the Medicaid State Plan.

(C) Activities conducted through this service may not include restrictive interventions as described in Chapter 45 section 18.

(iii) Case management services:

(A) Case management is a required service for any participant on the waiver. The case management service may be on a participant's plan as a monthly unit or 15 minute units, not to exceed 296 units every plan year, unless otherwise authorized by the ECC.

(B) To bill for a monthly unit of case management, a case manager shall document all billable activities provided during the month and must provide at least two hours minimum of documented service, with at least one hour of person-to-person contact with the participant or guardian per calendar month. The direct contact may include face-to-face meetings and phone conversations with the participant and guardian.

(C) The direct monthly contact shall be used to discuss waiver services, health, and safety topics with the participant through a phone call or personal visit to ensure the participant is satisfied with services and has no unmet needs.

(D) Billable activities include plan of care development, service coordination, monitoring of the plan of care, second-line medication monitoring, following up on concerns, service observation, team meetings, participant specific training conducted, service documentation review, face to face meeting with participants, guardians or family member relating to the plan of care or service delivery, advocacy and referral activities, crisis intervention coordination, coordination of natural supports and non-waiver resources, and home visits.

(E) To bill using fifteen (15) minute units, a case manager shall provide at least one (1) 15-minute unit per month for each waiver participant on his or her caseload. The number of 15 minute units used must be based upon the needs of the participant or guardian up to the approved amount authorized on the plan of care.

(F) When using 15 minute units, the case manager shall be required to complete a home visit to the participant in his or her home as follows:

(I) A monthly home visit is required for a participant who receives any type of residential services, including residential habilitation, special family habilitation home, and supported living services. The visit must be done in the home with the participant present.

(II) A quarterly home visit is required to participants not in residential or supported living services and must be done in the home with the participant present.

(III) The case manager may complete additional home visits for times of crisis or other times when a participant might request or need more frequent home visits.

(G) The case manager shall schedule and facilitate annual and semi-annual individual plan of care team meetings, and other team meetings when requested by the participant, guardian, member of the team, or the Division.

(H) The case manager shall give at least thirty (30) days advance written notice to team members and the Division for a plan of care meeting unless a shorter notification time is approved by the Division.

(I) The case manager shall follow Division requirements for facilitating and documenting team meetings.

(J) The case manager shall monitor the plan of care in accordance with Chapter 45, Waiver Provider Certification and Sanctions.

(iv) Child Habilitation Services:

(A) Child Habilitation Services provide participants ages zero (0) through seventeen (17) with regularly scheduled activities and supervision for part of a day, where services include formal and informal training, the coordination and intervention directed at skill development and maintenance, physical health promotion and maintenance, language development, cognitive development, socialization, social and community integration, and domestic and economic management.

(B) Services may provide supplementary staffing necessary to meet the child's exceptional care needs in a daycare setting, and do not include the basic cost of child care for ages birth through age twelve (12). Basic cost of child care means the rate charged by and paid to a childcare center or worker for children who do not have special needs.

(C) Services may not be approved on the Comprehensive waiver in excess of 9400 units per year. Services approved must be based on assessed need and fit within the person's assigned budget.

(D) A provider may receive reimbursement for up to two (2) participants at one time. A Child Habilitation provider employee may not supervise more than three (3) persons regardless of funding source during the provision of this service.

(v) Community Integration Services:

(A) Community Integration Services are available for participants ages twenty one (21) and older as a fifteen (15) minute unit. Services offer assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills, and activities and environments are designed to foster the acquisition of new skills, appropriate behavior, greater independence, community networking, and personal choice. Making connections with community members is a strong component of this service provision.

(B) Services must take place in a non-residential setting, separate from the participant's private residence or other residential living arrangement. Services are intended to be furnished in any of a variety of settings in the community and must not be limited to fixed-site facilities.

(C) Services must include options and opportunities for community integration, relationship-building, an increased presence in one's community, and adult educational supports.

(D) Services must help the participant plan for and access, participate, and interact with community members, businesses, volunteer activities, libraries, cultural, religious, or art centers, while building and maintaining social connections at least 50% of the time each week during the provision of services.

(E) This service must be delivered and documented differently from Adult Day Services to ensure specific integration activities are included.

(F) Providers may not bill for this service during times when the participant is receiving compensation for work activities.

(G) Tiered service rates must be based upon level of service need:

(I) Basic Level of Care for participants between a level 1 and 2.9 Level of Service Need score, which requires limited staff supports and personal attention to a participant daily due to a moderately high level of independence and functioning. Behavioral needs, if any, can be met with medication or informal direction by staff. The participant may have periods of time with indirect staff supervision where staff are onsite and available through hearing distance of a request.

(II) Intermediate Level of Care for participants between a level 3 and 4.9 Level of Service Need score, which requires full-time supervision with staff available on-site within line of sight due to significant functional limitations, medical or behavioral needs. Behavioral and medical supports are not generally intense and can be provided in a shared staffing setting. Regular personal attention is given throughout the day for personal care, reinforcement, community or social activities.

(III) High Level of Care for participants between a level 5 and 6 Level of Service Need score, which requires full-time supervision with staff available on-site within absolute line of sight and frequent staff interaction and personal attention for significant functional limitations, medical or behavioral needs. Support and supervision needs are moderately intense, but can still generally be provided in a shared setting unless otherwise specified in the plan of care. Frequent personal attention given throughout the day for reinforcement, positive behavior support, personal care, community or social activities.

(H) In order to help a participant with building meaningful relationships and social connections in the community with a more individualized approach, a participant with any level of service need score may add the high level of care rate to the plan of care for individual services or services with up to one other waiver participant where the entire time is spent solely in the community and not in a facility. Services that meet this criteria must have documentation that supports the community integration activities, measurable objectives, and active habilitation training.

(vi) Companion Services:

(A) Companion services are available to a participant age eighteen (18) or older and include non-medical care, supervision, socialization, assisting a waiver participant in maintaining safety in the home and community, and enhancing independence. Companions may assist or supervise the individual with such tasks as meal preparation, laundry, and shopping, but do not perform these activities as discrete services. Companions may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. Services may include assistance with activities of daily living and personal care as needed during the provision of services.

(B) Companion services units are available for individual services or in groups serving no more than three (3) participants total.

(C) Service may be provided up to nine (9) hours a in a calendar day except for special events or out of town trips.

(D) Service may be provided to a participant in a residential habilitation placement who does not want to attend a day service program periodically but still requires supervision in the home.

(vii) Crisis Intervention Services:

(A) Crisis Intervention services are available to a participant age eighteen (18) years or older in Residential Habilitation, Community Integration services, Prevocational, or Supported Employment Services.

(B) Services may be added to a plan for situations where a participant's tier level of habilitation services may not provide sufficient support for specific activities, medical conditions, or occurrences of behaviors or crisis, but the extensive supervision is not needed at all times. Crisis Intervention Service shall only be used to provide extra support from another staff to supervise a participant in the habilitation service during times of periodic behavioral episodes where the person is a danger to oneself or others, or when the participant has an occasional or temporary medically fragile situation and is at risk of imminent harm without the extra staff support.

(C) Crisis intervention services must be used for behavioral purposes and are not intended for watching the person should the behavior occur, but for the purpose of supporting the participant when the need arises, using positive behavior supports and non-violent, non-physical, crisis intervention services to de-escalate a situation, teach appropriate behaviors, and keep the participant safe until the participant is stable.

(D) Service is billed as a fifteen (15) minute unit and the quantity of service must be approved by the Division and be based on verified need, evidence of the diagnosis, or condition requiring this service.

(E) Documentation of progress and data on behaviors and the outcome of the intervention services must be submitted to the case manager and Division at the frequency specified in the approved plan of care.

(viii) Dietician:

(A) Dietician services shall be supported by a formal assessment completed by a registered dietician and must be prescribed by a physician.

(B) Providers must provide at least thirty (30) minutes of service to bill for Dietician services.

(C) The Dietician services must be for participants who show a pattern of chronic and unusual need requiring Dietician services. Chronic needs encompass conditions, such as severe obesity, poor food choices that compromise health, special diets approved by a physician for specific diagnoses, or severe allergies.

(ix) Environmental modification. Environmental modifications shall be approved pursuant to Chapter 44.

(x) Employment Discovery and Customization:

(A) Employment Discovery and Customization services are available to a participant age eighteen (18) or older to determine the strengths, needs, and interests of the participant relating to employment. Services include developing an employment opportunity through job carving, self-employment or entrepreneurial initiative, or other job development or restructuring strategies that result in job responsibilities being customized and individually negotiated to fit the needs of participants.

(B) Employment Discovery and Customization services may not duplicate reasonable accommodations and supports that may be necessary and expected of an employer for a participant to perform functions of a job that is individually negotiated and developed.

(C) Employment discovery and customization is a 1:1 support service and has a limited time frame of 12 months. This service is reimbursed at a fifteen (15) minute unit rate. An additional twelve (12) months may be approved by the Division upon review of the progress made the prior year.

(D) Employment Discovery and Customization services are capped at 400 units annually. When the service is approved, participants will receive 100 units to develop a strengths, needs, and interest assessment, and an employment plan. Once the employment plan is submitted to the Division, an additional 300 units may be approved to explore various types of job customization, self-employment, or entrepreneurial opportunities.

(xi) Homemaker:

(A) Homemaker services may consist of general household activities such as meal preparation and routine household care, and may be provided by a trained homemaker when the individual regularly responsible for these activities is unable to manage the home and care for oneself or others in the home, or when the person who usually does these things is temporarily unavailable or unable to perform the tasks.

(B) Homemaker services do not include any direct care or supervision of the waiver participant.

(C) Units of homemaker service must not exceed three (3) hours per week per household or 624 units annually. Homemaker services are not available to participants who receive residential habilitation or special family habilitation home services on the waiver.

(xii) Independent Support Broker:

(A) Independent Support Brokerage must include services to assist the participant or the legally authorized representative in arranging for, directing, and managing services that are being self-directed. The support broker shall assist in identifying immediate and long-term needs, budgeting, developing options to meet needs, teaching self-advocacy, assisting with employee grievances and complaints, and accessing identified supports and services. The Support Broker shall conduct practical skills training to enable participants and their legal representatives to independently direct and manage waiver services by providing information on how to recruit and hire direct care workers, manage workers, effectively communicate, and problem-solve.

(B) This service may not duplicate other waiver services, including case management.

(C) The service has a cap of 320 units annually.

(D) A Support Broker, when on a participant's plan of care, has the responsibility for training all of the participant's employees on the policy for reportable incidents and ensuring that all incidents meeting the criteria of the Division's Notification of Incident Process are reported.

(E) A Support Broker must review employee time sheets and the monthly Fiscal Management Service reports to ensure that the individual budget amount is being spent in accordance with the approved plan of care, and coordinate follow-up on concerns with the participant's case manager.

(F) Support Brokerage is an optional service for a participant or legally authorized representative who self-directs services. If an employer of record is struggling with self-directing responsibilities as determined by the Division, a Support Broker must be added to the person's plan of care in order for the participant to continue to self-direct. After a year of required support brokerage, the participant or representative may opt out of support broker services if a formal request is submitted to the Division and one of the following criteria is met:

(I) The participant or guardian, who is the employer of record, demonstrates the ability to choose workers, coordinates the hiring of workers, and coordinates the delivery of services.

(II) The employer of record self-directs services for one (1) year with no concerns, including hiring, firing, training, scheduling workers and reviewing timesheets in a timely manner.

(G) A Support Broker shall be free of any conflict of interest including employment with a certified waiver provider or provision of any other waiver service to the same participant.

(H) A Support Broker hired by the participant through self-direction shall only serve one (1) participant or two (2) participants who are siblings residing in the same household.

(I) If a participant hires a parent or stepparent as an employee of a direct care service, then the participant must have an actively involved, unrelated support broker to ensure there is a responsible person in addition to the participant to assume employer responsibilities.

(xiii) Individual Habilitation Training:

(A) Individual Habilitation Training is a specialized 1:1 intensive training service for a participant under age twenty-two (22) to assist with the acquisition or improvement in skills not yet mastered that will lead to more independence and a higher level of functioning. Individual Habilitation Training services are for participants who live with unpaid caregivers or who need less than twenty-four (24) hour paid supervision and support.

(B) Supports and training objectives must be part of the plan of care and may include: adaptive skill development; assistance and training on activities of daily living; transportation safety; navigation; building social capital and connections; and hobby skill development for work on fine or gross motor skills.

(C) Objectives must be specific and measureable, and data must be tracked and analyzed for trends. Summary reports on progress or lack of progress must be given to the case manager and participant or guardian monthly. Objectives shall be re-written as needed when skills are learned or training is not yielding progress.

(D) Supports may include facilitation of inclusion of the individual within a community group or volunteer organization; opportunities for the participant to join associations or community groups; opportunities for inclusion in a broad range of community settings including opportunities to pursue social and cultural interests; choice making; and volunteer time.

(E) Individual Habilitation Training is an hourly unit, which can be provided in different increments throughout the calendar day, as long as the total units billed equals at least 60 minutes.

(F) Individual Habilitation Training has a four (4) hour a day limit and units shall be approved based upon the participant's need and budget limit.

(xiv) Occupational therapy:

(A) Reimbursement for occupational therapy services shall require both a prescription and a treatment letter or recommendation from a physician.

(B) Providers of occupational therapy group services may seek reimbursement for providing such services to a group of up to three (3) participants at a time.

(C) Occupational Therapy services consist of the full range of activities provided by a licensed occupational therapist and services may be used for maintenance and the prevention or regression of skills.

(D) Services are available for a participant age twenty-one (21) and older.

(E) Service is available as a fifteen (15) minute unit for an individual session or as a group session unit, which requires a minimum of thirty (30) minutes in service in order to bill.

(xv) Personal care:

(A) Personal care services shall be provided on a 1:1 basis and include assistance to a participant to accomplish tasks ranging from hands-on assistance and performing a task for the participant to cuing the participant to perform a personal care task.

(B) Health-related personal care services may be provided for care relating to medical or health protocols, medication assistance or administration, and range of motion exercises. Health related services may be provided after staff are trained by the appropriate trainer or medical professional, and documentation of training is included in the staff person's personnel file.

(C) Services may include assistance in performing activities of daily living, such as bathing, dressing, toileting, transferring, or maintaining continence, and instrumental activities of daily living on the person's property, such as personal hygiene, light housework, laundry, meal preparation (exclusive of the cost of the meal), using the telephone, medication, money management, which are essential to the health and welfare of the participant, rather than that participant's family.

(D) A participant living in a non-residential service setting may receive up to 6000 units per year based upon the participant's assessed need and availability of funds within the participant's assigned budget.

(E) For a participant living in a residential service setting on the Comprehensive Waiver, who needs ongoing supervision and cannot attend a day service due to medical or health conditions the limit attendance in these programs, may receive up to 7280 units of personal care services per year based upon the participant's need and availability of funds within the participant's assigned budget.

(F) The amount of personal care services for a minor child provided by the child's legally authorized representative, parent or stepparent must be based upon individual extraordinary care needs as specified in the approved individualized plan of care and other assessments.

(G) For relative providers residing in the same household as the waiver participant, personal care provided by the relative provider in the home shall be for extraordinary care only and cannot exceed four (4) hours per day per participant unless approved by the Division's Extraordinary Care Committee.

(xvi) Physical therapy:

(A) Reimbursement for physical therapy services shall require both a prescription and a treatment letter or recommendation from a physician.

(B) Providers of physical therapy group services may seek reimbursement for providing such services to a group of up to three (3) participants at a time.

(C) Physical Therapy services may be used for maintenance and the prevention or regression of skills and assist participants to preserve and improve their abilities for independent functioning, such as range of motion, strength, tolerance, and coordination.

(D) Physical Therapy services are available for a participant age twenty-one (21) and older.

(E) Physical Therapy services are available as a fifteen (15) minute unit for an individual session or as a group session unit, which requires a minimum of thirty (30) minutes in service in order to bill.

(xvii) Prevocational:

(A) Prevocational services are available to a participant age twenty-one (21) or older and must be designed to create a path to integrated community-based employment in a job matched to the individual's interests, strengths, priorities, abilities, and capabilities.

(B) Services must provide learning and work experiences, including volunteer work, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services may include teaching concepts such as compliance, attendance, task completion, problem solving, interpersonal relationships, and safety.

(C) Services may be furnished in a variety of locations in the community and are not limited to provider facilities. Prevocational services may be provided at a volunteer worksite or mentorship locations for the purpose of teaching job preparedness for a specific type of work.

(D) Participation in prevocational services may not be required as a pre-requisite for individual or small group supported employment services furnished under the waiver.

(E) Participants receiving paychecks in prevocational services must be compensated by the participant's employer in accordance with applicable state and federal laws.

(F) Waiver reimbursement is not available for the provision of vocational services delivered in facility-based or sheltered work settings, where individuals are supervised for the primary purpose of producing goods or performing services.

(G) Prevocational services are time-limited and should not exceed twelve (12) consecutive months.

(H) An additional twelve (12) months may be approved by the Division in subsequent years with submission of an approved employment plan (through vocational rehabilitation, school district, or the waiver) and upon review of active progress made the prior year on finding employment opportunities, increasing work skills, time on tasks, or other job preparedness objectives.

(I) A monthly objective must be included in the provision of services relating to work readiness skills. These skills and objectives may include volunteering, mentoring, increasing involvement with community members, improving communication with community members, and accessing other resources to further employment development and potentially prepare the participant for work in the community. Progress on objectives must be reported monthly to the case manager, participant, and legally authorized representative.

(J) If there is no progress on prevocational training objectives or the employment pathway planning, a participant may not receive prevocational services in subsequent years and other waiver services may be accessed to meet the supervision and support needs of the participant.

(K) Tiered service rates must be based upon level of service need:

(I) Basic Level of Care for participants between a level 1 and 2.9 Level of Service Need score, which requires limited staff supports and personal attention to a participant daily due to a moderately high level of independence and functioning. Behavioral needs, if any, can be met with medication or informal direction by staff. The participant may have periods of time with indirect staff supervision where staff are onsite and available through hearing distance of a request.

(II) Intermediate Level of Care for participants between a level 3 and 4.9 Level of Service Need score, which requires full-time supervision with staff available on-site within line of sight due to significant functional limitations, medical or behavioral needs. Behavioral and medical supports are not generally intense and can be provided in a shared staffing setting. Regular personal attention is given throughout the day for personal care, reinforcement, community or social activities.

(III) High Level of Care for participants between a level 5 and 6 Level of Service Need score, which requires full-time supervision with staff available on-site within absolute line of sight and frequent staff interaction and personal attention for significant functional limitations, medical or behavioral needs. Support and supervision needs are moderately intense, but can still generally be provided in a shared setting unless otherwise specified in the plan of care. Frequent personal attention given throughout the day for reinforcement, positive behavior support, personal care, community or social activities.

(L) For each participant receiving this service, documentation must be maintained in the provider and case manager’s file that demonstrates prevocational services or a similar service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

(xviii) Residential Habilitation:

(A) Residential habilitation services shall consist of individually-tailored supports for a waiver participant age eighteen (18) or older on the Comprehensive Waiver to assist with the acquisition, retention, or improvement in skills related to living in the community. Services shall be provided appropriate to the level of supervision identified in the plan of care and include regular adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, which assist the participant to be as independent as possible and reside in the most integrated setting appropriate to his or her needs.

(B) Participants receiving residential habilitation shall have one primary residence and bedroom that is uniquely assigned to him or her, which is homelike in nature and decorated according to the participant's preferences.

(C) The participant must have immediate, on-site access to the provider of services inside the residence on a twenty-four (24) hour basis.

(D) Services shall not include payments for the cost of room and board, including the cost of building maintenance, upkeep and improvement.

(E) Residential Habilitation services are reimbursed using a daily unit based upon the level of service need of the participant, where the participant needs some level of ongoing twenty-four (24) hour support by a provider on site.

(F) Residential Habilitation may be delivered through self-direction as Shared Living, where the participant and other housemates own or lease the residence from an entity that is not a certified waiver provider. The employee hired through self-direction may serve up to three (3) people in shared living, but can serve no other people in a residential habilitation service.

(G) For a participant receiving this service, the participant will be assigned a tiered level of reimbursement as specified in an approved plan of care. Tier levels for this service align with the assessed Level of Service Need for the participant and the expectations of the service as specified in the definition. All supervision and supports delivered must align with the participant's plan of care.

(H) Tiered Level descriptions.

(I) Level 1– Participants receiving level 1 residential habilitation exhibit a high level of independence and functioning without significant behavioral or medical issues. A provider serving a participant at this level of funding must maintain staff available on-site with regular monitoring, support, and training during waking hours. Support and training must be aimed at increasing the participant's independence and described in the participant's plan of care. A provider must be available on-call on a twenty-four (24) hour basis.

(II) Level 2- Participants receiving level 2 residential habilitation exhibit a moderately high level of independence and functioning with few behavioral or medical issues that require minimal staff support, monitoring, or personal care. Level 2 requires a provider to be available on-site with regular monitoring, support, and training during waking hours. Support and

training must be documented in the plan of care and aimed at increasing the participant's independence and level of functioning while addressing behavioral and medical issues. Provider staff must be on-call on a 24 hour basis.

(III) Level 3- Participants receiving level 3 residential habilitation exhibit moderate functional limitations in their activities of daily living or behavioral support needs. Providers serving level 3 participants must maintain staff on-site throughout the service day with regular monitoring, support, and training during waking hours and staff support through the night in the residence. Support and training must be documented in the plan of care and aimed at increasing the participant's independence and level of functioning while addressing behavioral and medical issues. Provider staff must be on-call on a 24 hour basis.

(IV) Level 4- Participants receiving level 4 residential habilitation exhibit significant functional limitations, as well as medical or behavioral needs that are generally not intense and can be addressed in a shared staffing setting. Providers serving level 4 participants must be on-site, in the participant's residence, while the participant is receiving services. Level 4 participants shall receive regular personal attention throughout the day for training, personal care, reinforcement, positive behavior support, community, and social activities. Provider staff must provide support in the participant's residence through the night. Service details must be documented in the participant's plan of care.

(V) Level 5- Participants receiving level 5 residential habilitation exhibit significant and somewhat intensive functional limitations, as well as somewhat intensive medical or behavioral support needs that require small shared staffing to address. Providers serving level 5 participants shall maintain at least one (1) staff member on-site, within line of sight, during most awake hours that the participant is in this service. Services must include frequent personal attention throughout the day for training, personal care, reinforcement, community and social activities. Provider staff must provide support in the participant's residence through the night. Service details must be documented in the participant's plan of care.

(VI) Level 6- Participants receiving level 6 residential habilitation exhibit significant functional limitations due to high medical, behavioral, or personal care needs that require one or more direct care staff to address. Providers serving level 6 participants shall dedicate at least one (1) staff member on-site, within line of sight, during awake hours when the participant is in this service. Services must include frequent personal attention throughout the day for training, personal care, reinforcement, community and social activities. Provider staff shall provide support in the participant's residence through the night. Service details, including specific staffing ratios during the day and night, must be documented in the participant's plan of care.

(I) Residential habilitation services and respite services may not appear on the same individual plan of care except when:

(I) The participant is transitioning into a residential setting such as a group home; or

(II) Unpaid caregivers need respite when the participant spends time at home visiting on weekends or vacations.

(J) The provider shall provider residential habilitation services directly to the participant in the community or in the residence during both awake and sleeping time for a minimum of eight (8) hours in a twenty-four (24) hour period (from 12:00am-11:59pm) for the provider to be reimbursed.

(K) Participants shall be free to voluntarily leave their residential habilitation home, with the intent to return, for events such as vacations, family visits, or sleepovers. Providers shall not receive reimbursement while the participant is outside the residential habilitation home for these or other similar purposes, except that the provider may receive full reimbursement for the day that the participant returns to the residential habilitation provider home.

(L) A participant not yet receiving twenty-four (24) hour residential services who may be at significant risk due to extraordinary needs that cannot be met in their current living arrangement and require twenty-four (24) hour care may request Residential Habilitation services if the participant meets one of the following targeting criteria:

(I) A substantial threat to a person's life or health caused by homelessness or abuse/neglect that is either substantiated by Department of Family Services or corroborated by the Behavioral Health Division or Protection & Advocacy Systems, Inc.

(II) The person's condition poses a substantial threat to a person's life or health, and is documented in writing by a physician.

(III) The person has caused serious physical harm to him or herself or someone else in the home, or the person's condition presents a substantial risk of physical threat to him or herself or others in the home.

(IV) There are significant and frequently occurring behavior challenges resulting in danger to the person's health and safety, or the health and safety of others in the home.

(V) The person's critical medical condition requires ongoing twenty-four (24) hour support and supervision to maintain the person's health and safety.

(VI) Loss of primary caregiver due to caregiver's death, incapacitation, critical medical condition, or inability to provide continuous care.

(M) Any new residential habilitation placement must be approved by the Extraordinary Care Committee.

(xix) Respite:

(A) Respite is a short-term service that allows an unpaid caregiver, a Residential Habilitation provider who is not nationally certified, or a Special Family Habilitation Home provider to receive limited relief from the daily care of a participant. Services may include assistance with activities of daily living, medication assistance, and general supervision provided in the caregiver's home, the provider's home, or in community settings.

(B) Services must be primarily episodic in nature, and may not be used when parents or primary caregivers are working.

(C) A respite provider may serve up to two (2) unrelated participants at the same time or up to three (3) participants in the same family who live in the same household. A participant requiring 1:1 care must receive 1:1 respite services.

(D) A special family habilitation home provider may use respite from a different provider for a child receiving services in their home.

(E) Respite is reimbursed as a fifteen (15) minute unit or a daily rate.

(F) On the Comprehensive Waiver, the total number of fifteen (15) minute units available for respite per plan year is 5000. When respite services exceed nine (9) hours a day, the provider must bill as a daily unit.

(G) A provider may provide supervision to other non-waiver participants requiring support and supervision, and must limit the total combined number of persons they are providing services to at a given time to no more three (3) persons unless approved by the Division.

(xx) Self-Directed Goods and Services. Self-Directed Goods and Services shall be approved pursuant to Chapter 44.

(xxi) Skilled nursing:

(A) Skilled Nursing services are medical care services delivered to individuals with complex chronic or acute medical conditions and performed within the Nurse's scope of practice as defined by Wyoming's Nurse Practice Act. Skilled Nursing services include the application of the nursing process including assessment, diagnosis, planning, intervention and evaluation, and the administration, teaching, counseling, supervision, delegation, and evaluation of nursing practice and the execution of the medical regimen.

(B) Services needed must be specifically prescribed by a physician on a form specified by the Division and require a level of expertise that is undeliverable by non-medical trained individuals.

(C) The delivery of Skilled Nursing services is limited to those individuals who possess an unencumbered license issued by the Wyoming State Board of Nursing.

(D) Skilled Nursing services may be used when the Medicaid State Plan Services have been exhausted, are not available in the person's area, are not available due to services denied by the home health provider, or the hours of need for the service are not available by the home health provider.

(E) A billable skilled nursing service unit is considered to be a service that is provided up to fifteen (15) minutes and that involves one-on-one direct patient care. Units billed for rounded up services may not exceed eight (8) units within a one hour timeframe for multiple participants in a single location by one provider nurse.

(F) Skilled nursing services must address the ongoing chronic or acute medical issues for which the service is needed and must include direct patient care or services. Skilled Nursing providers cannot be reimbursed for watching television with a participant, transportation to and from doctor appointments, time spent charting, time spent in waiting room with participant, or time spent completing paperwork, or similar non-nursing activities.

(xxii) Special Family Habilitation Home:

(A) Special Family Habilitation Home services must include participant specific, individually-designed and coordinated training within a family host home environment that does not include the participant's biological, step, or adoptive parents.

(B) This service is only available to participants under the age of twenty (20) years old on the Comprehensive waiver who are receiving this service before the effective date of this rule. The service is not open to newly enrolled participants.

(C) The Special Family Habilitation Home provider shall be the primary caregiver and assume twenty-four (24) hour care of the individual.

(D) This service may not be used in conjunction with Individual Habilitation Training services.

(E) The provision of Special Family Habilitation Home services includes personal care needs. Plans of care may not include the personal care service.

(F) This service pays for support to an individual who needs support twenty-four (24) hours a day. The provider shall be in the residence of the participant providing service during both awake and sleeping time for a minimum of (8) hours in a twenty-four (24) hour period (from 12:00am-11:59pm) for the provider to be reimbursed.

(G) Family visits and trips are encouraged. The provider shall not be reimbursed for days that the participant is absent, but may request reimbursement for the day the participant returns home from a trip.

(H) The Special Family Habilitation Home provider shall provide both formal and informal training opportunities to participants served. The schedule must be individualized and the training objective must be meaningful. Progress on objectives shall be reported to the case manager monthly.

(xxiii) Specialized equipment. Specialized equipment shall be provided pursuant to Chapter 44.

(xxiv) Speech, hearing, and language services:

(A) Reimbursement for speech, hearing, and language services requires both a prescription and a treatment letter or recommendation from a physician.

(B) Speech, hearing, and language services are available for a participant age twenty-one (21) and older and must consist of the full range of activities provided by a licensed speech therapist. Services may include screening and evaluation of participants with respect to speech function; development of therapeutic treatment plans; direct therapeutic intervention; selection, assistance, or training with augmentative communication devices; and the provision of ongoing therapy.

(C) Services through the waiver can be used for maintenance and the prevention or regression of skills.

(D) A minimum of forty-five (45) minutes of service per session must be provided per unit in order to bill for one unit.

(E) Providers of speech, hearing, and language group services may seek reimbursement for providing such services to a group of up to three (3) participants at one time.

(xxv) Subsequent Assessment:

(A) Subsequent assessments may be provided as part of ongoing case management and will include the necessary collaboration of professionals to assess the needs, characteristics, preferences and desires of the waiver participant.

(B) Case managers shall initiate and oversee subsequent assessments, regardless of payment source, including the psychological assessment needed for continued eligibility, and any other approved assessments necessary to determine the participant's needs and are not available through the Medicaid State plan.

(C) A subsequent assessment must be prior authorized by the Division.

(xxvi) Supported Living:

(A) Supported Living Services assist participants who do not require ongoing twenty-four (24) hour supervision but do require a range of community-based supports and habilitation training to be able to live in their own home, family home, or rental unit.

(B) Services must be based upon need and may include assisting with activities of daily living, performing routine household activities to maintain a clean and safe home, assistance with health issues, medications and medical services, teaching the participant to access the community, and building personal relationships with others. In some cases, the service may require twenty-four (24) hour emergency assistance.

(C) The supported living service daily rate is based on seven (7) hours of service a day and a provider shall provide a minimum of four (4) hours of documented service per calendar day for reimbursement. One (1) staff or provider can be reimbursed for up to three (3) participants during a daily unit of service provided.

(D) Supported living services can be billed at a fifteen (15) minute unit rate for a maximum of 5,400 units per plan year for services provided to a group up to two (2) or three (3) participants, or 3,900 fifteen (15) minute units per plan year provided to an individual participant.

(E) Supported living is a habilitation service, which means training on objectives is required as part of the provision of services and objective progress must be reported to the participant, guardian, and case manager monthly.

(F) The plan of care must identify either the daily unit or the individual or group 15-minute unit, based on the participant's need. Both the daily unit and the fifteen (15) minute unit may be on the participant's plan of care but cannot be used on the same day.

(xxvii) Supported Employment:

(A) Supported employment services must provide support and assistance to a participant age eighteen (18) or older who needs intensive support to find and maintain a job in a competitive, integrated work setting because of his or her disability. Services must be conducted in settings where persons without disabilities are employed. Services must assist the participant with sustaining paid work. Services may include supervision and training.

(B) Supported employment services must be provided at a work site where persons without disabilities are employed. Services may provide reimbursement for the adaptations, supervision and training required to assist a participant with sustaining paid work. Reimbursement shall not include payment for supervisory activities rendered in the normal course of business.

(C) Objectives must be identified in the participant's plan that support the need for job coaching and a plan to lessen the job coaching over time, if possible. The job coach must be in the immediate vicinity of the participant during services and available for immediate intervention and support.

(D) Documentation shall be maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

(E) Services shall be provided as either in an individual 1:1 setting or as part of a group.

(I) Group supported employment services may be provided to a participant age eighteen (18) or older if the group ranges from two (2) to nine (9) persons. Group employment for groups larger than nine (9) people will not be reimbursed by the waiver.

(1.) Small Group Supported Employment services consist of intensive, ongoing support that enable a participant to perform in a regular work setting, including mobile work crews or enclaves.

(2.) Small Group Supported Employment may include employment in community businesses or businesses that are part of a provider organization that do not segregate or shelter participants from the general community, and where people without disabilities are also employed in positions other than job coaches.

(II) Individual Supported Employment services are 1:1 supports provided to a participant to obtain and maintain employment.

(1.) Services may assist a participant to work in a competitive or customized job, be self-employed, or work in an integrated work setting in the general workforce where the participant is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by an individual without a disability.

(2.) Individual Supported Employment must be provided in a community-integrated employment setting, unless the support is to develop customized employment, self-employment, or home-based employment, subject to prior approval of the Division.

(3.) Supported Employment services may be provided in the home if the participant is receiving services to prepare for a community work experiences and competitive employment or if the employment is a Division approved home-based business venture.

(xxviii) Supported Employment Follow Along:

(A) Supported Employment Follow Along services enable a participant, who is paid at or above the federal minimum wage, to maintain employment in an integrated community employment setting.

(B) Service is provided for or on behalf of a participant through intermittent and occasional job support, communicating with the participant's supervisor or manager, whether in the presence of the participant or not. A provider may use this service for regular contact and follow-up with the employer and participant in order to reinforce and stabilize the job placement, facilitate natural supports at the work site, provide individual program development, write tasks analyses, or conduct monthly reviews, termination reviews, and behavioral intervention.

(C) This service may cover support through phone calls between support staff and the participant's managerial staff.

(D) A provider shall be reimbursed at a fifteen (15) minute rate for up to 100 units annually based upon individual need in order to maintain employment.

(E) This service does not reimburse for transportation, work crews, public relations, community education, in service meetings, or individual staff development.

(xxix) Transportation:

(A) Transportation service on the waiver is a gap service to enable participants to gain access to an employment location, community services, activities, and resources as specified by the plan of care when a service provider is not needed at the event. This service is not intended to replace formal or informal transportation options, like the use of natural supports, city transportation services, and travel vouchers.

(B) Transportation services under the waiver shall be offered in accordance with an individual's plan of care and whenever possible, family, neighbors, friends, or community agencies, that can provide this service without charge or with other resources, must be utilized.

(C) This service does not include transportation to medical appointments required under 42 CFR 431.53 and transportation services available under the Medicaid state plan.

(D) Transportation services will be reimbursed based on mileage used. This service is capped at $2,000 per year.

(E) Transportation services cannot be utilized in conjunction with or to access other waiver services that specify in the service scope that transportation is covered in the rate for that service.

Section 8. Waiver Cost Limits and Individual Budget Amounts.

(a) The allocation of Medicaid waiver funds that may be available to a participant to purchase services is based on his or her assessed needs according to a fair and equitable distribution of funding.

(b) Eligibility shall be determined pursuant to Section 5 of this Chapter before an individual budget amount is determined.

(c) The Supports Waiver.

(i) The Supports Waiver shall assign an individual budget amount based on:

(A) The participant's age group, whether or not the participant has reached the age of 21;

(B) An average cost for the assessed service needs for individuals in the participant's age group;

(C) The participant's access to services available to the participant through programs funded under Section 110 or 504 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.);

(D) An amount for annual case management services;

(E) A temporary funding increase when needed for an emergency situation, which is approved by the Extraordinary Care Committee, not to exceed the overall cost limit for the Supports Waiver.

(ii) Any participant eligible for the Supports Waiver shall also be given a Level of Service Need score in order to determine eligibility and priority order for Comprehensive Waiver funding.

(d) The Comprehensive Waiver.

(i) The Comprehensive Waiver shall fund services for participants whose needs are in excess of the Supports Waiver cap, meet the emergency criteria as specified by the ECC, or are transitioning from a state-funded institution that meets reserved capacity criteria.

(ii) Waiver recipients active on the Adult or Child DD Waivers before April 1, 2014 will automatically go on the Comprehensive Waiver unless they choose otherwise.

(iii) The Comprehensive Waiver shall assign an individual budget amount to each Comprehensive Waiver participant based on the following factors:

(A) Functional and medical assessments, including the ICAP assessment, and past approved plans of care;

(B) The participant's age group, whether or not the participant has reached the age of 21;

(C) The participant's living situation;

(D) The participant's need for a higher level of services;

(E) An amount for annual case management services.

(F) A temporary or permanent increase or decrease as determined by the Clinical Review Team or Extraordinary Care Committee.

(iv) The factors in subsection (d) (ii) determine the participant's Level of Service Need score in order to plan for appropriate services and supports. The Level of Service Need score shall also be used to determine priority listing on the wait list for the Comprehensive Waiver.

(v) Supports to the participant through waiver services must align with the Level of Service need scoring rubric associated with the person's score. Standards of care for each level include:

(A) Level 1, which means the participant requires few supports weekly due to a high level of independence and functioning compared to one's peers. This participant is independent with ADLs but may follow checklists as reminders. No significant behavioral or medical issues that cannot be controlled with medication and routine medical care. Participant requires minimal support services that can be provided within a few hours per week, and can be left alone in the home or community for extended periods of time.

(B) Level 2, which means the participant requires infrequent care and limited supports daily due to a moderately high level of independence and functioning. Some days may

not require any support. Behavioral needs, if any, can be met with medication or informal or infrequent verbal redirection by caregivers, which may or may not require a PBSP. There may be a need for day services and intermittent residential support services to assist with certain tasks, and the participant can be unsupervised for several hours at time during the day and night.

(C) Level 3, which means the participant requires limited personal care or regular supervision due to a moderate level of functional limitations in activities of daily living, requiring staff presence and some physical assistance. Behavioral needs, if any, are met through medication, informal direction by caregivers, or occasional therapy (every one to two weeks). Participant does not require 24-hour supervision – generally able to sleep unsupervised – but needs structure and routine throughout the day. Intermittent personal attention should be given daily for training, personal care, community or social activities.

(D) Level 4, which means the participant requires regular personal care or close supervision due to significant functional limitations, medical or behavioral conditions. Therapy and medical care may be needed monthly in addition to support from staff. Behavioral and medical supports are not generally staff-intensive and may be provided in a shared staffing setting. Regular attention is needed throughout the day for training, personal care, reinforcement, community or social activities.

(E) Level 5, which means the participant requires extensive personal care or constant supervision due to behavioral or medical concerns or due to significant functional limitations concerns, including frequent and regular on-site staff interaction and support. Therapy and medical care may be needed bi-monthly in addition to support from staff. Behavioral and medical concerns must be addressed with written behavioral or medical plans and protocols. Support needs are highly intense, but can still generally be provided in a shared staff setting. Staff must provide line of sight supervision and frequent personal attention must be given throughout the day for training, reinforcement, positive behavior support, personal care, community or social activities.

(F) Level 6, which means the participant needs total personal care or intense supervision throughout the day and night. Supervision by a sole staff on-site (not shared) must be conducted by at least line of sight, with much of the staff's time within close proximity providing direct support during all waking hours. At times, the participant may require the full attention of two staff for certain activities of daily living and in response to certain behavioral events. Therapy and medical care may be needed weekly in addition to support from staff. Typically, this level of service is only needed by someone with intense behaviors, not just medical needs alone. There is no ratio flexibility from the amount approved in the plan of care. Behavioral and medical supports require written plans or protocols to address support needs.

(vi) A participant's individual budget amount on the Comprehensive Waiver may not exceed the current annual average cost of a resident at the Wyoming Life Resource Center. A participant who needs services in excess of this amount must have the plan of care and budget approved by the Division's Extraordinary Care Committee, who shall work with the participant's providers and plan of care team to evaluate the provision of services, monitor service delivery and participant outcomes, improve services and supports, make plans to improve outcomes for the participant, and reduce the plan cost over no more than a three (3) year period.

Section 9. Clinical Review Team.

(a) The Division's Clinical Review Team (CRT) shall be comprised of the Division's licensed Psychologist, the Division's Administrator, a Division manager, the Division's Registered Nurse, the assigned Participant Support Specialist, and a behavioral specialist. When appropriate, the CRT may also include the Medicaid Medical Director and the Division's Psychiatrist. The CRT may consult with other specialists in the field.

(b) The CRT shall review submitted requests involving:

(i) Concerns about a Level of Service Need score; or

(ii) Requests for extraordinary service or support needs for the initial budget assignments given the first year the participant is funded onto the Comprehensive waiver.

(c) A request may be made by the participant through the participant's Plan of Care team, if they can demonstrate that a participant's level of service need score for the Comprehensive Waiver does not reflect the participant's assessed needs.

(d) A request must be submitted on the form provided by the Division and accompanied by additional information that the participant and the participant's Plan of Care team does not see adequately captured in the Inventory for Client and Agency Planning (ICAP) or in the information stored electronically by the Division for the case.

(e) The CRT has the authority to request additional assessments, including a new ICAP, a Supports Intensity Scale, or another appropriate and standardized assessment targeted for a specific diagnosis or condition, or refer the case to the Extraordinary Care Committee.

(i) The additional assessment in these cases may provide more detailed information about the person's support needs and assist the CRT in evaluating the need for a different Level of Service Need or Extraordinary Service or Support.

(ii) Information from the ICAP, along with information from other assessments and information submitted by the participant's team shall be used to make the final decision on the request.

(iii) The additional assessments and information CRT reviews may result in a Level of Service Need increase, decrease, or no change.

(f) Any eligible individual denied the requested level of service need score or a requested extraordinary support or service under this section may request administrative review of that decision pursuant to Chapter 4, Administrative Hearings.

Section 10. Self-Directed Service Delivery.

(a) The services that may be self-directed include Child Habilitation, Companion, Homemaker, Individual Supported Employment, Independent Support Brokerage, Individual

Habilitation Training, Personal Care, Residential Habilitation Shared Living, Respite, Self-Directed Goods and Services, Supported Living.

(b) A participant or guardian shall be given information regarding the option to self-direct waiver services at least once a year.

(c) Self-Direction opportunities are available to participants who:

(i) Live in his or her own private residence or the home of a family member; or

(ii) Reside in other living arrangements where services (regardless of funding source) are furnished to three (3) or less persons unrelated to the proprietor.

(d) To self-direct waiver services, the participant or legally authorized representative or other designee, shall act as the Employer of Record and use a Financial Management Service on contract with the Division.

(e) A participant may only self-direct services if the Financial Management Service contractor has open slots for new people to enroll, based upon the contracted capacity.

(f) The Financial Management Service shall assist the participant in being the Employer of Record.

(g) The Division shall provide the recommended wage ranges for all self-directed services.

(h) The Employer of Record shall be responsible to recruit, hire, schedule, evaluate and supervise self-directed employees. The Employer of Record shall have the budgetary authority to negotiate and set wages and payment terms for all services received.

(i) The Employer of Record shall hire employees to provide waiver services and work with the Financial Management Service to determine that the potential employee meets the general and specific provider standards for the service being provided.

(j) The Employer of Record shall work with the employee hired through self-direction to determine the specific tasks to be completed during the provision of services, the employee's schedule, and how to document services and report documentation and timesheets to the Employer and Financial Management Service. The Employer of Record shall ensure documentation is available to the case manager by the tenth (10^{th}) business day of the month following the month in which services were provided.

(k) When the Employer of Record and the employee have reached agreement on the services to be provided, schedule, and rate, the Financial Management Service shall track the rate and services authorized and ensure the employee wages are paid in accordance with state and federal laws.

(l) Employees hired through self-direction shall document services provided in accordance with Chapter 45 and the agreed upon manner between the Financial Management Service and the Employer of Record. The Employer of Record must maintain documentation according to Wyoming Medicaid Rules, Chapter 3, Provider Participation.

(m) The Employer of Record, with assistance from the support broker and case manager as needed, is responsible for reviewing employee documentation of the services provided and the employee timesheets to ensure accuracy with the type, scope, amount, frequency, and duration of services agreed upon in the plan of care.

(n) A participant may choose to voluntarily terminate self-direction at any time during the plan year and shall work with the case manager to transition to other services or providers. The case manager must disenroll the participant from the Financial Management Service within thirty (30) days.

(o) A participant may be involuntarily terminated from the use of self-direction if:

(i) The participant or Employer of Record is found to misuse waiver funds,

(ii) The participant's health and welfare needs are not adequately being met,

(iii) The Division, the Division of Healthcare Financing, or the Medicaid Fraud Control Unit identifies situations involving the commission of fraudulent or criminal activity associated with the self-direction of services; or

(iv) The participant chooses not to receive self-directed services for sixty (60) days after active enrollment begins.

Section 11. Wait List Process.

(a) The Division shall maintain a wait list for each waiver when there is insufficient funding to add additional participants to that waiver or no open slots in the waiver as approved by the Centers for Medicare and Medicaid Services.

(b) Participants who qualify for the Comprehensive Waiver may receive Supports Waiver funding and services and also apply to and be on the wait list for the Comprehensive Waiver.

(c) The Division shall prioritize eligible individuals on the wait lists on a first come, first serve basis. Funding opportunities will be given to the person who spent the longest time waiting for services starting from the date that the individual was determined eligible.

(d) Before being added to a Waiver wait list, the individual must be determined eligible as specified in Section 5 of this Chapter.

(e) For people with the same date of eligibility on the wait list, the Division will use the date that the "Selection of Case Manager" form was received by the Division to determine which individual's name goes first.

(f) The level of service need score and individual budget amount shall be determined for each individual on the wait lists. An eligible individual who needs services in excess of the Supports Waiver and has a level of service need score of 4 or higher may apply for the Comprehensive Waiver and may also be placed on the Comprehensive Waiver wait list, if funding or slots are not available.

(g) The Comprehensive Waiver shall reserve capacity each year for individuals who have resided in a Wyoming institution, such as an ICF/ID, nursing home, Psychiatric Residential Treatment Facility, BOCES, prison, jail, or an inpatient psychiatric hospital and who have been:

(i) In residence at the institution for at least two (2) years;

(ii) On a BHD wait list for at least two (2) years; or

(iii) Previously on a BHD waiver a minimum of two (2) years prior to being institutionalized.

Section 12. Emergency Services.

(a) An emergency case involves an eligible person that calls for immediate action or an urgent need for waiver services, including physical care and supervision in the least restrictive and most appropriate environment necessary to maintain the person's vital functions, without which services the person would suffer irreparable harm or death because of one of the following criteria:

(i) An immediate threat, or a high probability of immediate danger to the life, health, property, or environment of the eligible person or another individual because of the eligible person's medical, mental health, or behavioral condition.

(ii) A loss of the person's primary caregiver due to death, incapacitation, critical medical condition, or inability to provide continuous care. A caregiver is defined as any person, agency, or other entity responsible for the care, both physical and supervisory, of a person because of:

(A) A family relationship;

(B) Voluntary assumption of responsibility for care;

(C) Court ordered responsibility or placement;

(D) Rendering services in a residential program;

(E) Rendering services in an institution or in a community-based program; or

(F) Acceptance of a legal obligation or responsibility of care to the person.

(iii) Homelessness, which means a situation where a person lacks access to an adequate residence with appropriate resources to meet his/her support and supervision needs, and without such support, there is evidence of serious harm to the person's life or health. A person residing in a homeless shelter is not a cause for an ECC consideration by itself.

(iv) A case involving a person removed from the home due to abuse, neglect, abandonment, exploitation, or self-neglect substantiated by the Department of Family Services (DFS), Protection & Advocacy Systems, Inc., or law enforcement.

(v) A residential service request for a waiver participant or a person on the wait list not receiving 24-hour residential services, whose health or safety is at significant risk due to

extraordinary needs that cannot be met in the current living arrangement because of one of following criteria:

(A) A substantial threat to a person's life or health caused by a situation listed in (c)(i)(D) of this section that is either corroborated by the Department of Family Services, Protection & Advocacy Systems, Inc., or law enforcement;

(B) A situation where the person's health condition or significant and frequently occurring behavioral challenges poses a substantial threat to the person's own life or health, or to others in the home.

(C) A situation where the person's critical medical condition requires ongoing twenty-four (24) hour support and supervision to maintain the person's health and safety that cannot be met in the current living situation;

(D) The loss of the eligible person's primary caregiver due to death, incapacitation, critical medical condition, or inability to provide continuous care.

(vi) Any person who requests that the Division consider an emergency case shall be directed to work with the person's chosen case manager. The Division shall assist the person in reviewing options to choose a case manager and complete eligibility determination requirements as quickly as possible.

(vii) Emergency cases shall be referred to the Division's Extraordinary Care Committee pursuant to section 13 of this chapter.

(viii) An individual who has not been deemed eligible for waiver services may complete the eligibility process and request emergency services. No emergency services may be provided to ineligible persons.

Section 13. Extraordinary Care Committee.

(a) The Extraordinary Care Committee (ECC) shall be composed of a Division waiver manager, a Medicaid manager, the Participant Support Specialist presenting the case, and a representative from the Department's fiscal unit. Members may consult other specialists in the field as appropriate.

(b) The ECC may only approve additional funds for participant cases if funding is available in the Division's waiver budget appropriation.

(c) The ECC shall review emergency cases as defined by Section 12 of this Chapter or other extraordinary cases that include either:

(i) A significant change in service need due to the onset of a medical condition or injury, or

(ii) A request referred from the Clinical Review Team or Division staff and approved by the Participant Support Manager for evaluation, consultation, and a funding decision due to an extraordinary service need, a specialized equipment item or a home modification that require

consideration based on an assessed need, or a requested transition to a more independent setting, or an individual community integrated employment opportunity.

(d) Emergency cases can arise for a person who is eligible for covered services but is on the wait list, or for participants currently receiving Comprehensive or Supports waiver services who may be determined to be in an emergency situation pursuant to (a) of this Section.

(e) The ECC shall have the authority to approve, modify, or deny a submitted funding request for any person deemed eligible for a waiver operated by the Division or refer the case to the Clinical Review Team.

(f) An ECC request must contain verification of how the participant's situation meets emergency criteria. Evidence should at least include as applicable:

(i) Written statements or reports from the other state or regional agencies that support the emergency case including specific incidents, notes related to the type of condition or injury, witnesses, follow-up, treatment summaries, and any documented accounts of events by witnesses.

(ii) Documentation of other approaches or supports that have been attempted.

(iii) Written statements from a physician or licensed psychologist explaining the significant change in the participant's functioning limitations that result in an assessed need for additional supports or services, and how the person's life or health is in jeopardy without such supports and services.

(iv) Evidence that the person does not qualify for funding or services through any other agency that would alleviate the emergency situation.

(v) For persons requesting services or supports due to homelessness, evidence that:

(A) Other community resources, such as a homeless shelter, victim's shelter, or other temporary residence are not available or appropriate; or

(B) The temporary shelter is insufficient to meet the person's immediate health and safety needs and there is evidence of immediate and serious harm to the person's life or health if temporarily in a temporary shelter.

(C) Due to other conditions of the emergency or the person's condition, waiver services would be the necessary and appropriate intervention.

(g) Decisions of the ECC shall be by majority and rendered in writing.

(h) The Division Administrator or designee shall document a review of the decisions and may approve, deny or order more action in a case. In cases of a tie vote among members, the Administrator shall issue the final vote.

(i) The participant or legally authorized representative shall receive documentation of the decision within ten (10) business days of the decision.

(j) Any eligible individual denied services under this section may request administrative review of that decision pursuant to Chapter 4, Administrative Hearings.

Section 14. Prohibited Use of Waiver Funds.

(a) The following services are not eligible for waiver services reimbursement:

(i) The care of individuals residing in a hospital, nursing facility, ICF/ID, or other institutional placement;

(ii) A spouse of the participant, a legally appointed guardian of a participant age 18 and over, or an owner or officer of a provider organization serving their ward cannot directly or indirectly receive reimbursement for providing waiver services for that ward.

(iii) Room and board, except when provided as part of respite in a facility, other than a private residence, approved by Medicaid;

(iv) Services currently covered under the Medicaid state plan;

(v) Services to an individual if it is reasonably expected that the aggregate cost of these services furnished to all individuals would exceed the cost of services provided in an ICF/ID, calculated by using the highest annual ICF/ID rate;

(vi) Service settings required by another state agency, such as the Department of Family Services or Department of Education;

(vii) Educational services that may be provided during a normal, regular, or adjusted school day; or

(viii) Vocational services that are available to the individual through the Department of Education, Department of Workforce Services, or other state agency.

(b) No service that is the responsibility of the school system will be authorized as a waiver service. The Division will not authorize waiver services for the hours the child is attending school or in a vocational rehabilitation program. Regular school hours and days apply for a child who receives home schooling.

(c) Any individual eligible for funding for specialized services under the Developmental Disabilities Services Act must apply for and accept any federal Medicaid benefits for which they may be eligible and benefits from other funding sources within the Department; the Department of Education, specifically including the Department of Workforce Services and Division of Vocational Rehabilitation; and other agencies to the maximum extent possible.

Section 15. Denial of Funding.

(a) The Division may deny or revoke authorization for waiver services for any of the following reasons:

(i) The individual fails to meet waiver clinical eligibility criteria;

(ii) The individual fails to meet financial eligibility criteria;

(iii) The eligible individual has not met emergency criteria and no other waiver funding opportunities are available;

(iv) A waiver funding opportunity is not available;

(v) The individual or legal representative has not consented to waiver services;

(vi) The individual or legal representative has chosen to receive ICF/ID services;

(vii) The individual, his/her legally authorized representative or other person on his or her behalf has not supplied needed information;

(viii) Intensity of services does not reflect the need for ICF/ID level of care services;

(ix) The individual's needs are not being met through waiver services;

(x) The individualized plan of care has not been implemented;

(xi) A plan of services and supports to protect the individual's health and welfare cannot be developed or maintained;

(xii) The legislature has not appropriated sufficient fiscal resources to fund all services for all persons determined eligible for waiver services;

(xiii) Funding for requested waiver services is available as a similar service from other sources;

(xiv) The eligible individual or legal representative has failed to apply for, and accept any federal Medicaid benefits for which she or he may be eligible, or benefits from other funding sources within the Department of Health, the Department of Education, Department of Workforce Services, or other agencies to the maximum extent possible.

(xv) The eligible individual or legal representative has not signed documentation required by the Department;

(xvi) The eligible individual or legal representative has failed to cooperate with, or refused the services funded by the Division;

(xvii) The individual, under the age of twenty-two (22), could receive educational services during a normal, regular, or adjusted school day.

Section 16. Interpretation of Chapter.

(a) The order in which the provisions of this Chapter appear is not to be construed to mean that any one provision is more or less important than any other provision.

(b) The text of this Chapter shall control the titles of its various provisions.

Section 17. Superseding Effect. This Chapter supersedes all prior rules or policy statements issued by the Division, including Provider Manuals and Provider Bulletins, which are inconsistent with this Chapter.

Section 18. Severability. If any portion of this Chapter is found to be invalid or unenforceable, the remainder shall continue in full force and effect.